MEDI-CAL UPDATE

Pharmacy
Bulletin 572

Billing and Policy
Pharmacy Bulletin 572 **December 2003**

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Stair-Climbing Wheelchair: New Benefit

Effective for dates of service on or after September 23, 2003, the iBOT Mobility System (stair climbing wheelchair) is a Medi-Cal benefit, subject to prior authorization. Providers must bill using HCPCS code X3160 (unlisted wheelchairs). The recipient must have a medical condition that necessitates the use of a wheelchair and a medical need for vertical ambulation within the home. Recipients whose disability limits them from work and who are vocationally eligible (excluding the elderly) must undergo evaluation by the Department of Rehabilitation.

TAR Requirements

Treatment Authorization Requests (TARs) must be submitted with a signed prescription from a licensed physician trained in the use of the wheelchair in accordance with the manufacturer's recommendations. If the recipient is enrolled in the California Children's Services (CCS) program or the Genetically Handicapped Persons Program (GHPP), documentation must be submitted with the service authorization request to the CCS or GHPP programs for determination of medical necessity.

Additionally, a rehabilitation therapist approved by the Johnson and Johnson subsidiary, Independence Technology, must have evaluated and determined that the recipient has the necessary physical and cognitive skills to operate the stair climbing wheelchair. This evaluation must be submitted in writing with the TAR. *This information is reflected on manual replacement page dura bil dme 4 (Part 2).*

Unlisted Wheelchairs, Accessories and Replacement Parts: Updated Reimbursement Methodology

Effective for dates of service on or after January 1, 2004, Medi-Cal reimbursement for the purchase of wheelchairs and wheelchair accessories with no specified maximum allowable rate (listed as "By Report") will change to comply with recent legislation (Assembly Bill [AB] 747, Chapter 659, Statutes of 2003).

AB 747 mandates reimbursement at the lesser of:

- The amount billed pursuant to the *California Code of Regulations* (CCR), Title 22, Section 51008.1, or
- The actual acquisition cost plus a markup to be established by the Department of Health Services (DHS), or
- The Manufacturer's Suggested Retail Price (MSRP) reduced by a percentage discount not to exceed 20 percent.

Please see **Unlisted**, *page 2*

Unlisted *(continued)*

To implement the requirements of AB 747, claims billed for wheelchairs, wheelchair accessories and replacement parts for patient-owned equipment billed to the program using codes with no specified maximum allowable rate ("By Report") will be reimbursed as follows:

- The amount billed pursuant to CCR, Title 22, Section 51008.1, or
- The manufacturer's purchase invoice amount, plus a 67 percent markup, or
- The percentage of MSRP as follows:

Power Wheelchairs

Aggregate MSRP *	Percentage of MSRP
$1 – $5,000	90
$5,001 – $14,000	85
$14,001 +	80

Manual Wheelchairs

Aggregate MSRP *	Percentage of MSRP
$1 – $1,500	90
$1,500 – $4,000	85
$4,001 +	80

* The total aggregate MSRP includes the wheelchair base and all accessories billed for each date of service (for example, date of delivery).

Scooters
Payment for all scooters, regardless of the aggregate MSRP, will be reimbursed at 80 percent of the MSRP.

Payment for wheelchairs, wheelchair accessories and replacement parts to providers who do not have a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified technician on staff will be reimbursed at 80 percent of MSRP regardless of the total aggregate MSRP.

Reimbursement will be determined based on the documentation submitted with the *HCFA 1500*. Providers may submit either the manufacturer's purchase invoice or the MSRP. The MSRP must be an amount established by the manufacturer prior to August 1, 2003.

Claim Submission Requirements
All claims require the following information:

- Manufacturer's purchase invoice or MSRP (a catalog page) dated prior to August 1, 2003
- Item description
- Manufacturer name
- Model number
- Catalog number
- Completion of the *Reserved For Local Use* field (Box 19), or on an attachment, with the total aggregate MSRP of the wheelchair and wheelchair accessories or replacement parts
- Completion of the *Reserved For Local Use* field (Box 19), or on an attachment, with the name of the employed RESNA-certified technician

Claims with an approved *Treatment Authorization Request* (TAR) received by the San Francisco Medi-Cal field office or an approved California Children's Services (CCS) *Service Authorization Request* (SAR) received by the local CCS office prior to January 1, 2004 will be reimbursed using the current reimbursement methodology. The current methodology is either cost plus a 67 percent markup or 100 percent of MSRP. Providers must submit a copy of their TAR/CCS authorization with the claim to verify the date of receipt by the field/local office.

Please see **Unlisted**, *page 3*

Unlisted *(continued)*

Claim Denials
Claims that do not include all of the above documentation will be denied. Claims billed with an unlisted HCPCS code (X3160 or X3162) when a listed HCPCS code is available will be denied.

Billing Reminders
When billing for replacement parts to repair a patient-owned wheelchair, providers are reminded to use an established HCPCS code. In those instances when an established code is not available, HCPCS code X2996 may be used. For example, when billing for replacement batteries, HCPCS codes X3150 through X3158 or X3230 through X3234 must be used.

Reimbursement Update: Durable Medical Equipment and Orthotic Appliances

Effective for dates of service on or after September 22, 2003, the reimbursement rates for the following Durable Medical Equipment (DME) and orthotic appliance codes have been adjusted in compliance with the implementation of State budget Assembly Bill 1762:

HCPCS Code	Description
E0117	Crutch, underarm, articulating, spring assisted, each
E1037	Transport chair, pediatric size
L0462	Three rigid plastic shells, soft liner, includes straps and closures, includes fitting and adjustment

The updated information is reflected on manual replacement pages dura cd 2 and 9 (Part 2) and ortho cd1 2 and 19 (Part 2).

HCPCS/CPT-4 Code Updates: Modifications to Select Policies

Many of the medical and reimbursement policies for codes affected by the 2003 HCPCS/CPT-4 update were published in the September 2003 *Medi-Cal Update*. Additional policies are highlighted below. All information is effective for dates of service on or after September 22, 2003.

DME Replacement Parts Billing
HCPCS codes A4556 (pair of electrodes) and/or A4557 (pair of lead wires) are not separately reimbursable with the rental or same-day initial purchase of an apnea monitor (E0618, without recording feature, or E0619, with recording feature). *The updated information is reflected on manual replacement page dura bil oxy 10 (Part 2).*

Prior Authorization Changes
"By Report" HCPCS codes L3911 (wrist-hand-finger orthosis, elastic, prefabricated), L5782 (addition to lower limb prosthesis, heavy duty) and L5995 (addition to lower extremity prosthesis, heavy duty) require prior authorization.

Modifiers for Prosthetic Codes
New prosthetic codes K0556 – K0559 require modifiers -LT (left side) and/or -RT (right side). Modifier -RP (replacement or repair) may be used for tracking purposes only. Providers must use codes L7510/L7520 for reimbursement of repairs to prosthetic appliances. Modifier -Y4 (undeliverable custom item, without sales tax) is also allowable, if appropriate. *The updated information is reflected on manual replacement page ortho 2 (Part 2).*

Please see **HCPCS**, *page 4*

HCPCS *(continued)*

Cranial Molding Helmet Update
HCPCS code S1040 (cranial molding helmet) requires prior authorization, which must include the name and address of the FDA-approved lab that made the helmet. The following are currently approved laboratories:

- Ballert Orthopedic (Cranial Molding Helmet)
- Beverly Hills Prosthetics Orthotics (Cranial Symmetry System)
- Children's Hospital and Regional Medical Center in Seattle, WA (Clarren Helmet)
- Loma Linda University Medical Center, Rehab Institute, Department of O&P (LLUMC Cranial Remolding Helmet)
- Orthomerica in Orlando, FL (STARband, STARlight Cranial Remolding Orthosis, Clarren Helmet)
- Orthotic & Prosthetic Lab, Inc. in Webster Grove, MO (Cranial Molding Helmet)

The updated information is reflected on manual replacement page ortho 8 (Part 2).

Medi-Cal Benefit List Changes
The following HCPCS codes are not Medi-Cal benefits: A4653, E0636, E1802 and S9145.

HIPAA Implementation: Modifier -LT/-RT Exceptions for O & P

Effective for dates of service on or after September 22, 2003, the following Orthotic and Prosthetic (O & P) procedure codes do not require -LT (left side) and/or -RT (right side) modifiers:

L1500 – L1520	L3652	L4210	L7900	L8047
L1620	L3660	L6360	L8002	L8230
L1700	L3675	L6384	L8015	L8310
L2640	L4000	L6570	L8040	
L3650	L4205	L7360 – L7368	L8041	

These codes may be billed without modifiers.

Prosthetic repair and labor codes L7510 and L7520 require an -LT and/or -RT modifier unless the provider indicates in the *Reserved For Local Use* field (Box 19) of the claim, or as an attachment, that the repair is not for a limb prosthesis.

Also effective for dates of service on or after September 22, 2003, lift/build-up codes L3300 – L3334 may be billed with either the modifier -LT (left side) or -RT (right side). Lifts are reimbursable for one side only. Lift/build-up codes are restricted to two billing occurrences in 180 days for the same recipient by any provider.

This information is reflected on manual replacement pages ortho 2, 3 and 10 (Part 2).

2004 HCPCS and CPT-4 Codes: Billing Update

The 2004 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and *Healthcare Common Procedure Coding System* (HCPCS Level II codes) will become effective for Medicare on January 1, 2004. Medi-Cal has not yet adopted the 2004 updates. Do not use the 2004 code updates to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

ICD-9-CM Diagnosis Codes: 2004 Updates

Providers may use the following diagnosis codes for claims with dates of service on or after January 1, 2004. Please refer to the 2004 *International Classification of Diseases, 9th Revision, Clinical Modification, 6th Edition* (ICD-9-CM) for the description of each diagnosis code.

Additions

079.82	289.82	530.21	728.88	850.11	V53.91
255.10	289.89	530.85	752.81 *	850.12	V53.99
255.11	331.11 §§	600.00 *	752.89	959.11	V54.01
255.12	331.19	600.01 *	766.21 †	959.12	V54.02 §
255.13	331.82	600.10 *	766.22 †	959.13 *	V54.09
255.14	348.30	600.11 *	767.11 †	959.14	V58.63
277.81	348.31	600.20 *	767.19 †	959.19	V58.64
277.82	348.39	600.21 *	779.83 †	996.57	V58.65
277.83	358.00	600.90 *	780.93	V01.82	V64.41
277.84	358.01	600.91 *	780.94	V04.81	V64.42
277.89	414.07 +	607.85 *	781.94	V04.82 ††	V64.43
282.41	458.21	674.50 **	785.52	V04.89	V65.11 ** ‡
282.42	458.29	674.51 **	788.63	V15.87	V65.19
282.49	480.3	674.52 **	790.21	V25.03 ** ‡	V65.46
282.64	493.81	674.53 **	790.22	V43.21	E928.4
282.68	493.82	674.54 **	790.29	V43.22	E928.5
289.52	517.3	719.7	799.81 ‡‡	V45.85	
289.81	530.20	728.87	799.89	V53.90	

* Restricted to males
† Restricted to ages 0 thru 1 years
§ Restricted to ages 0 thru 21 years
‡ Restricted to ages 5 thru 70 years
\+ Restricted to ages 40 thru 99 years
** Restricted to females
†† Restricted to ages 0 thru 3 years
§§ Restricted to ages 0 thru 50 years
‡‡ Restricted to ages 10 thru 99 years

Revisions

The descriptions for the following ICD-9-CM diagnosis codes are revised: 282.60, 282.61, 282.62, 282.63, 282.69, 414.06, 491.20, 491.21, 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.90, 493.92, V06.1 and V06.5.

Inactive

Effective for dates of service on or after January 1, 2004, the following ICD-9-CM diagnosis codes are inactive and no longer reimbursable: 255.1, 277.8, 282.4, 289.8, 331.1, 348.3, 358.0, 458.2, 530.2, 600.0, 600.1, 600.2, 600.9, 719.70, 719.75, 719.76, 719.77, 719.78, 719.79, 752.8, 766.2, 767.1, 790.2, 799.8, 850.1, 959.1, V04.8, V43.2, V53.9, V54.0, V64.4 and V65.1.

County Medical Services Program: Rate Adjustment

Effective for dates of service on or after November 1, 2003, the County Medical Services Program (CMSP) implemented a 10 percent rate reduction for services rendered to CMSP recipients. This reduction applies to CMSP recipients with the following aid codes: 50, 84, 85, 88, 89 and 8F. This reduction does not apply to inpatient services.

Remittance Advice Details (RADs) will identify payments affected by these rate reductions with RAD code message 477: "CMSP (County Medical Services Program) reduction cutback."

Note: This reduction is not related to the Medi-Cal reimbursement reduction of 5 percent (required by the *Welfare and Institutions Code* [W&I], Section 14105.19).

Information about this rate reduction is reflected on provider manual replacement page county med 12 of the Part 1 manual.

CTP Services Payment Reduction

Effective for dates of service on or after January 1, 2004, reimbursements for Children's Treatment Program (CTP) services will be reduced by 5 percent. The reductions will remain in effect until further notice.

Although CTP services have been identified as exempt from the 5-percent Medi-Cal reimbursement reduction mandated under the Budget Act of 2003 (Assembly Bill 1762), projected CTP expenditures for the 2003-2004 fiscal year currently exceed revenues. Section 16934.5(b)(3)(c) of the *Welfare and Institutions Code* (W & I) states that the CTP may "…adjust payments for the remainder of the fiscal year to providers on a pro rata basis in order to ensure that expenditures do not exceed available revenues."

In addition, the reduction is consistent with the recent action by Medi-Cal to reduce provider reimbursements by 5 percent (refer to this month's Part 1 *Medi-Cal Update*). As stated in the *CTP Medical Services Policies and Procedures Manual*, "Reimbursement is provided at current Medi-Cal rates. (As Medi-Cal increases or reduces the level of reimbursement, CTP level of reimbursement will also change.)"

Family PACT
Planning • Access • Care • Treatment

Contraceptive Supplies: Billing Reminder

Family PACT policy requires providers to document items, actual quantity and "at cost" expense in the *Reserved For Local Use* field (Box 19) when billing for code X1500 (other contraceptive supplies). Claims submitted without the required documentation may be denied and will be subject to post-audit review.

Replacement pages for the Family PACT *Policies, Procedures and Billing Instructions* (PPBI) manual will be issued in a future mailing to Family PACT providers. For more information regarding Family PACT, call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays.

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Dates and Locations
The following dates and locations are scheduled through April 2004:

January 14, 2004
Yuba City
Best Western Bonanza Inn
1001 Clark Avenue
Yuba City, CA 95991
For directions, call
(530) 674-8824

February 24, 2004
Anaheim
Radisson Hotel Maingate
1850 South Harbor Blvd
Anaheim, CA 92802
For directions, call
(714) 750-2801

March 9, 2004
Merced
Ramada Inn
2000 East Childs Avenue
Merced, CA 95340
For directions, call
(209) 723-3121

March 24, 2004
Bakersfield
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
For directions, call
(661) 323-7111

April 21, 2004
Stockton
Courtyard by Marriott
3252 West March Lane
Stockton, CA 95219
For directions, call
(209) 472-9700

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation and Update Session Registration
Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Completing Provider Orientation and Update Session
Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance.* Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information
For more information regarding the Family PACT Program, please call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages
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Part 2

Remove and replace:	compound comp 1/2, 5 thru 14 *****
	compound ex 1 thru 4 *****
	drug 3/4*****
	dura bil dme 1 thru 4
	dura bil oxy 7 thru 10
	dura cd 1/2, 7 thru 10
	iv sol spec 3 thru 5 *****
	ortho 1 thru 4, 7 thru 10
	ortho cd1 1/2, 19/20
	pcf30-1 comp 1/2, 13 thru 16 *****
Remove:	pcf30-1 ex 1 thru 12
Insert:	pcf30-1 ex 1 thru 9 ***** *(new)*
Remove and replace:	pcf30-1 spec 1 thru 4 *****
	reimbursement 7/8 *****, 11/12 *****
	reject cd pos 1 thru 10 *****
Remove and replace forms at the end of the *Subacute Care Programs: Level of Care for Adults and Children* section:	*Information for Authorization/Reauthorization of Subacute Care Services—Adult Subacute Program* (form DHS 6200 A) *****
	Information for Authorization/Reauthorization of Subacute Care Services—Pediatric Subacute Program (form DHS 6200) *****
Remove and replace:	tar submis 1/2 *****
	tax 7/8 *****

* Pages updated/corrected due to ongoing provider manual revisions.